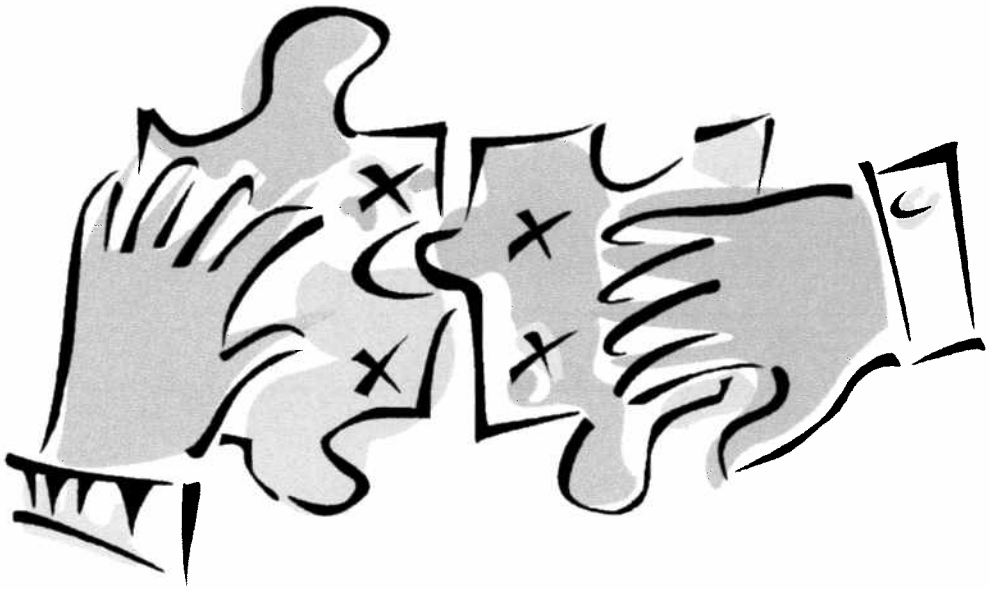
A Guide for Long-Term Care Services in Virginia



Virginia Department of Medical Assistance Services
Division of Long-Term Care

September 2008

Division of Long-Term Care: At A Glance

The Division of Long-Term Care (LTC) administers the provision of Medicaid services to seniors and persons with disabilities. This includes ensuring the health, safety, and welfare of Medicaid long-term care participants; program and policy development; program operations; regulatory development; legislative review; provider and participant training; education; and development of LTC initiatives and special reports. The focus of LTC is on the health, safety, and welfare of all persons who receive Medicaid long-term care services.

The Division has three units: LTC Policy and Special Program Development; Care Coordination Services; and Quality Management Review.

1. The LTC Policy and Program Development Unit is responsible for the development of long term care policy, regulations, LTC contracts, special projects, consumer-directed programs, Medicaid waiver application renewals, Money Follows the Person (MFP) Demonstration Project, and the development of a Quality Improvement Program for nursing facilities.
2. The Care Coordination Services Unit is responsible for administration of the Technology Assisted Waiver, Individual and Family Developmental Disabilities Services (IFDDS) Waiver, Alzheimer's Assisted Living (AAL) Waiver, and Program of All-Inclusive Care for the Elderly (PACE). Level of Care reviews for all waiver particiapants are performed in this Unit.
3. The Quality Management Review Unit is responsible for quality management reviews (QMRs) of waiver participants and providers, the development of an automated QMR tool and database, the development of CMS quality assurances and the Pre-Admission Screening program. The Unit performs QMR for nursing facilities (including specialized care), long-stay hospitals, and in-patient and outpatient rehabilitation programs. The Unit administers the Elderly and Disabled with Consumer Direction (EDCD) Waiver, HIV/AIDS Waiver, Intellectual Disabilities/Mental Retardation (MR) Waiver, and the Day Support Waiver and develops policy for several facility programs as well as durable medical equipment.

   For more information about the Division of Long-Term Care or DMAS, please visit http://www.dmas.virginia.gov/ or call the Division of Long-Term Care at (804) 225-4222.

I. LONG-TERM CARE SERVICES

There are various options available to individuals who meet the requirements for long-term care services including home- and community-based and facility care.

When considering service options, remember that Medicaid is the *payer of last resort.* Medicaid long-term care services cannot be considered until it is determined that an appropriate plan of care must include Medicaid-funded long-term care services.

For publicly-funded long-term care services (such as nursing facility (NF), assisted living facility (ALF), or home- and community-based waiver services), the individual must be pre-screened and deemed eligible for services. A complete assessment must be made before screeners can determine service options.

Preadmission screening is not contingent upon a person applying to determine financial eligibility for Medicaid coverage. This often occurs at the same time a person is seeking determination if they qualify based on functional/medical nursing needs. This cannot be a requirement for preadmission screening completion.

Explore which program is most appropriate to meet the care needs of the individual. Programs are geared to offer a package of services relevant to the needs of the specified population.

***This booklet is intended for screeners of publicly-funded long-term care services, recipients, caregivers, and providers in Virginia. Periodic updates may be found at www.dmas.virginia.gov/ltc-home.htm.**

WHAT ARE MEDICAID-FUNDED LONG-TERM CARE SERVICES? / REPORTING ABUSE, NEGLECT, AND EXPLOITATION?

II. REPORTING ABUSE, NEGLECT, OR EXPLOITATION

ADULTS

Section 63.2-1610 of the *Code of Virginia* states that any person employed by a public or private agency or facility and working with adults is mandated to report suspicion of abuse, neglect, or exploitation. He or she must report it to the local Department of Social Services, Adult Protective Services (APS) or to the 24-hour toll free APS hotline at: 1-888-832-3858 (ADULT).

CHILDREN

For suspected maltreatment of children, mandated reporters must immediately report suspicions to the local department of social services or the 24-hour toll-free Child Abuse and Neglect Hotline at: 1-800-552-7096 (in-state); 804-786-8536 (out-of-state)

*Remember as a mandated reporter you or your employer must report immediately.

III. QUESTIONS TO ASK TO DETERMINE SERVICE NEEDS

Should Medicaid-funded long-term care services be considered?

NO:
If an appropriate service plan can be developed without Medicaid services, recommend and refer to appropriate community services organizations, such as:

1) Centers for independent living
2) Church or resource groups
3) Health insurance carriers
4) Local area agencies on aging
5) Local community services boards
6) Local departments of health
7) Local departments of social services
8) Other community services groups

YES:
If an appropriate plan of care cannot be developed with community services, consider the Medicaid long-term care service options. Medicaid services can be offered in combination with other community services OR without other services depending on the individual's service plan.

Does the individual have adequate supports to reside safely at home?

NO:
If the individual does not have adequate care giving support, consider eligibility for facility-based options based on the individual's level of care needs.

YES:
If the individual has adequate care giving support networks, consider eligibility for home- and community-based services.

The following are publicly funded long-term care service options. Please see Sections VI and VII of this guide for specific program criteria.

FACILITY-BASED SERVICE OPTIONS INCLUDE:

- Assisted Living Facility (ALF), Residential or Regular Assisted Living
- Nursing Facility (NF)
- Specialized Care (provided in a NF with specialized medical needs such as ventilator care, or complex tracheostomy care for adults. For children, the criteria include vents; complex care issues; and comprehensive rehabilitation.)

HOME-BASED SERVICE OPTIONS INCLUDE:

- Alzheimer's Assisted Living Waiver
- Day Support Waiver
- Elderly or Disabled with Consumer Direction (EDCD) Waiver
- HIV/AIDS Waiver
- Individual and Family Developmental Disabilities Services Waiver (IFDDS)
- Intellectual Disabilities/Mental Retardation (MR) Waiver
- Program for All-Inclusive Care for the Elderly (PACE)
- Technology Assisted Waiver

SHOULD MEDICAID-FUNDED LONG-TERM CARE SERVICES BE CONSIDERED?

III. QUESTIONS TO ASK TO DETERMINE SERVICE NEEDS (con't.)

When considering home-based services, it is essential that the screener carefully consider whether a **safe and appropriate service plan** can be developed for each individual. Medicaid is prohibited from providing home care when it appears that a participant may not be safe in the home at all times.

Questions to ask when considering whether a safe service plan can be developed:

1) Will the individual be safe and have his or her care needs met when the waiver provider is not in the home?
2) If the waiver plan of care cannot meet the individual's overall care needs, can a safe and adequate plan of care be developed to meet his or her remaining care and supervision needs?
3) If the individual has sufficient cognitive impairments (such as a diagnosis of dementia), will adequate supervision be provided when waiver services are not in the home?
4) In case of an emergency, such as fire, will the individual have adequate support and resources to exit the residence safely?
5) If the individual requires skilled nursing care, are there formal/informal supports qualified to provide the necessary care?
6) Does the individual live in an environment that ensures the individual's health and/or safety and is adapted to his or her functional needs (e.g., grab-bars in the bathroom where needed, wheelchair accessibility ramp, voltage and wiring to support necessary durable medical equipment)?

If the screener answers NO to any of the above questions, the individual may not be appropriate for home care through a waiver program. The screener should assess whether the necessary supportive services are available through other community resources.

Note: If NO is the answer to #6 and the individual qualifies for certain waivers, environmental modifications may be available through a waiver program.

IV. PRIMARY AGENCIES INVOLVED IN THE PROVISION OF LONG-TERM CARE AND COMMUNITY-BASED SERVICES

Department of Medical Assistance Services: In addition to providing reimbursement for long-term care, prior authorization, and quality management reviews, DMAS oversees contracts with DSS, local health departments, acute care hospitals, and other screening entities to conduct preadmission screening for services. For more information, call the DMAS Help Line, 804-786-6273 or 1-800-552-8627 or visit www.dmas.virginia.gov. Or providers may access on-line help through the following website: http://www.dmas.virginia.gov/ltc-Pre_admin_screeners.htm

Department of Social Services: The DSS Adult Services Program is offered through 120 local departments of social services. The population served is persons age 60 and over and persons aged 18-59 with disabilities. Services include home-based care, adult protective services, adult day care, and adult foster care. For information, call (804) 726-7000 or (800) 552-3431 (toll-free) or visit www.dss.virginia.gov.

Department for the Aging: VDA is the single state agency designated to administer federal Older Americans Act funds, including funding of the Office of the State Long-Term Care Ombudsman. VDA also provides information, assistance, and referrals for aging services. VDA funds 25 area agencies on aging (AAA's). For more information, call 1-800-552-3402 or (804) 662-9333 or visit http://www.vda.virginia.gov/contactus.asp.

Department of Health: This Department's primary responsibility is public health activities. For more information, visit http://www.vdh.state.va.us/ContactUs.htm.

Department of Mental Health, Mental Retardation, and Substance Abuse Services: DMHMRSAS is the state agency responsible for coordination of mental health, mental retardation, and substance abuse services through the local community services boards (CSBs). The agency also administers the Level II screening, which is a Federal requirement for nursing facility placement. For waiver placement for individuals with an identified diagnosis of mental illness, mental retardation, or a related condition, the local community services board (CSB) must complete the DMAS101A/B process prior to waiver services beginning. For information, contact 804-786-3921 or visit www.dmhmrsas.virginia.gov/contactus.htm.

Department of Rehabilitative Services: DRS offers consumer-directed home care services through the Personal Assistance Services (PAS) Program. Recipients must have physical and/or sensory disabilities to qualify. For more information, call (800) 662-7000 or (800) 552-5019 or visit www.vadrs.org.

WHICH STATE AGENCIES ARE INVOLVED IN LONG-TERM CARE?

The Role of Public Partnerships, LLC (PPL)

PPL is a national organization dedicated to assisting organizations implement consumer-direction and providing consumers individual choices about the services they receive, how they are delivered and by whom within a defined service plan. DMAS has contracted with PPL to provide fiscal intermediary services for consumer-directed Medicaid participants including criminal background checks on potential employees, receiving, verifying and processing all time sheets, maintaining payroll records and processing all tax forms and payments for the IRS. PPL processes enrollment, employment documents, payroll, invoices and withholds, deposits, and files taxes on behalf of participant's who self-direct care in Virginia's Medicaid Waivers.

PPL's expanded role in the MFP project: PPL is responsible for tracking and reimbursing local transition coordinator agency's expenditures for transition services for each MFP enrolled participant and for the distribution of payments to vendors for goods and services purchased. PPL will conduct desk audits to validate the legitimacy of items/services purchased, provide direct reimbursement of expenditures to community-based agencies, and produce monthly spending reports. A secure website is available that provides case managers and transition coordinators access to individual expenditure and balance information for transition services. This website will enable on-line submission of claims reimbursement requests, tracking individual monetary balances, and will provide the ability to generate reports.

For additional information, please visit http://www.publicpartnerships.com/ or call (804) 200-4001.

V. COMPREHENSIVE ASSESSMENT

- The Virginia Uniform Assessment Instrument (UAI) is used to assess the long-term care needs of the elderly and people with disabilities to provide appropriate services and to develop an effective and efficient system of quality affordable services.
- Virginia requires the use of the Virginia UAI for all publicly funded long-term care services.
- Functioning is assessed on five dimensions: social resources, economic resources, mental health, physical health, and activities of daily living (ADLs).
- The assessment is both a PROCESS and a PRODUCT.
- The UAI ensures easy and equitable access to appropriate services for individuals at all levels of long-term care.
- For providers, it presents a comprehensive picture of the individual and the individual's needs and is intended to facilitate the transfer and sharing of individual information among providers in order to address service needs.
- For the agencies of the Commonwealth, it aids in case management, monitoring, evaluation, and balancing of long-term care needs of each participant requiring such services.
- Virginia has developed standardized decision criteria tied to the UAI, including levels of care in ALFs, Medicaid-funded nursing facility placement, or home and community-based care waiver services.
- The Virginia UAI form can be found at http://www.dmas.virginia.gov/downloads/forms/UAI.pdf.

General Points in Completing the UAI

- The individual is the primary source of information. If the individual is unable to accurately respond, or there is some question about the response, seek supplementary information from other sources.
- The form does not have to be completed in any prescribed order, although the questions have a logical flow. If you are just beginning as an assessor, follow the form from beginning to end. As you gain familiarity and comfort with the assessments, adapt the flow of questions to the individual situation. The form must be completed in its entirety.
- The UAI does not have to be completed in a single session; although, sometimes a Preadmission Screening or an ALF assessment may need to be completed quickly.
- If using the UAI as an assessment tool only for your agency, then obtaining the information through multiple visits may be the best course of action. Persons' needs may change from day to day and multiple visits will help you to determine the individual's true situation.
- If the UAI is for internal use and has been used for multiple re-assessments in your agency, complete a new, clean UAI using the most current information. Make sure to keep the previous UAIs to maintain an individual case history.
- To be sure that the UAI is completed correctly, you must have a copy of the *User's Manual: Virginia Uniform Assessment Instrument*. Use the manual definitions and procedures when you assess the individual. If you do not know the definitions and procedures, your assessment is likely to be inaccurate. The manual can be found at http://www.dmas.virginia.gov/downloads/pdfs/ltc-UAI_User_Manual.pdf.
- Training on the Virginia UAI can be obtained from VCU VISSTA at www.vcu.edu/vissta.

WHAT IS COMPREHENSIVE ASSESSMENT? / RATING OF FUNCTIONAL DEPENDENCIES

VI. RATING OF FUNCTIONAL DEPENDENCIES USING THE UAI

The rating of functional dependencies must be based on the individual's ability to function in a community environment, not including any institutionally induced dependence. The following abbreviations shall mean: I = independent; d = semi-dependent; D = dependent; MH = mechanical help; HH = human help.

Bathing
Without help **(I)**
MH only **(d)**
HH only **(D)**
MH and HH **(D)**
Is bathed **(D)**
Does not bathe (D)

Toileting
Without help day or night **(I)**
MH only **(d)**
HH only **(D)**
MH and HH **(D)**
Is toileted (D)
Is not toileted (D)

Bowel Function
Continent **(I)**
Incontinent less than weekly **(d)**
External/Indwelling Device **OR** Ostomy self-care **(d)**
Incontinent ≥ weekly **(D)**
Ostomy not self-care **(D)**

Eating/Feeding
Without help **(I)**
MH only **(d)**
HH only **(D)**
MH and HH **(D)**
Spoon fed **(D)**
Syringe or tube fed **(D)**
Fed by IV or clysis **(D)**

Joint Motion (NF)
Within normal limits **(I)**
Limited motion **(d)**
Instability corrected **(I)**
Instability uncorrected **(D)**
Immobility **(D)**

Dressing
Without help **(I)**
MH only **(d)**
HH only **(D)**
MH and HH **(D)**
Is dressed **(D)**
Is not dressed **(D)**

Transferring
Without help **(I)**
MH only **(d)**
HH only **(D)**
MH and HH **(D)**
Is transferred **(D)**
Is not transferred **(D)**

Bladder Function
Continent **(I)**
Incontinent ≤ weekly **(d)**
External device self- care **(d)**
Indwelling catheter self- care **(d)**
Ostomy self-care **(d)**
Incontinent ≥ weekly **(D)**
External device, not self- care **(D)**
Indwelling catheter, not self-care **(D)**
Ostomy not self-care **(D)**

Mobility
Goes outside without help **(I)**
Goes outside MH only **(d)**
Goes outside HH only **(D)**
Goes outside MH and HH **(D)**
Confined moves about **(D)**
Confined does not move about **(D)**

Medication Administration (NF Only)
No medications **(I)**
Self-administered, monitored < weekly **(I)**
By lay persons, monitored < weekly **(I)**
By Licensed/Professional nurse and/or monitored weekly or more **(d)**
Some or all by Professional nurse **(D)**

Medication Administration (ALF Only)
Without assistance **(I)**
Administered, monitored by lay person **(D)**
Administered, monitored by professional staff **(D)**

Behavior Pattern and Orientation
Appropriate OR Wandering/Passive< weekly + Oriented **(I)**
Appropriate OR Wandering/Passive < weekly + Disoriented some spheres; some or all of the time **(I)**
Wandering/Passive ≥ Weekly + Oriented **(I)**
Appropriate or Wandering/Passive < weekly + Disoriented All Spheres some or all of the time **(d)**
Wandering/Passive > Weekly + Disoriented some spheres; some or all of the time **(d)**
Wandering/Passive > weekly + Disoriented all spheres; some or all of the time **(d)**
Abusive/Aggressive/ Disruptive < weekly **(d)**
Abusive/Aggressive/ Disruptive > weekly + disoriented **(D)**
Abusive/Aggressive/Disruptive < weekly **OR** > weekly + Disoriented all spheres all time **(D)**
Semi-Comatose or Comatose for both Behavior and Orientation **(D)**

Please see the *User's Manual: Virginia Uniform Assessment Instrument (revised 7/05)* for more detailed definitions.

VII. FACILITY-BASED SERVICES

If an individual is eligible for facility-based services, consider whether an assisted living facility (ALF), a nursing facility (NF), or specialized care is most appropriate. The participant must be given a choice between facility placement and waiver services, and a choice between service providers.

ASSISTED LIVING FACILITY (ALF)

ALFs provide maintenance and care for four or more adults who may have limited functional capabilities. This service option provides two levels of care: residential living and regular assisted living. Residential living is the basic level of care. Medicaid only pays for regular assisted living.

RESIDENTIAL LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in only one of seven ADLs; OR
2. Rated dependent in one or more of four selected IADLs; OR
3. Rated dependent in medication administration.

REGULAR ASSISTED LIVING LEVEL OF CARE IN AN ALF:

1. Rated dependent in two or more of seven ADLs; OR
2. Rated dependent in behavior pattern.

A participant cannot be admitted to an ALF if he or she has a "Prohibited Condition" as follows:

- Ventilator dependency;
- Dermal ulcers III and IV, except those stage III ulcers that are determined by an independent physician to be healing;
- Intravenous therapy or injections directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia;
- Airborne infectious disease in a communicable state that requires isolation of the participant or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold;
- Psychotropic medications without appropriate diagnosis and treatment plans;
- Nasogastric tubes;
- Gastric tubes except when the participant is capable of independently feeding himself and caring for the tube;
- An imminent physical threat or danger to self or others is presented by the participant;
- Continuous licensed nursing care (seven-days-a-week, 24-hours-a-day) is required by the participant;
- Placement is no longer appropriate as certified by the participant's physician;
- Maximum physical assistance is required by the participant as documented by the UAI and the participant meets Medicaid NF level-of-care criteria, unless the participant's independent physician determines otherwise. Maximum physical assistance means that a participant has a rating of total dependence in four or more of the seven ADLs as documented on the UAI;
- The ALF determines that it cannot meet the participant's physical or mental health care needs;
- Other medical and functional care needs that the Board determines cannot be met properly in an ALF.

Assessment Process:

- For public pay participants, an authorized public human services agency assessor completes the assessment (local departments of social services, area agencies on aging, community services boards, centers for independent living, local departments of health, state facilities operated by DMHMRSAS, acute-care hospitals, medical units of state correctional facilities, and independent physicians contracting with DMAS).
- ALF assessments are required prior to admission, at least annually, and whenever there is a significant, permanent change in the participant's condition.
- For private pay participants, a trained ALF staff member may complete the assessment.

Forms:

- **Residential Assisted Living:**
  - Page 1-4 of the UAI, **plus** questions related to behavior pattern and medication administration
  - Completed DMAS-96 form
- **Regular Assisted Living:**
  - Completed UAI (all 12 pages)
  - Completed DMAS-96 form

Points to Consider:

Does the individual lack enough support to remain at home but prefers to remain in the least-restrictive facility setting? If yes, then authorization to the residential or regular assisted living program may be appropriate.

WHAT ARE THE CRITERIA FOR ASSISTED LIVING FACILITY SERVICES? / CRITERIA FOR NURSING FACILITY & SPECIALIZED CARE?

NURSING FACILITY (NF)

To be eligible for NF care, an individual must have both the necessary functional and medical/nursing needs. Home and community-based care waiver services and other service options must be carefully discussed and carefully considered prior to selecting a NF as the service option.

NF Criteria:

NF CATEGORY 1:

Rated dependent in 2 to 4 ADLs: ❑ *YES*; **PLUS**
Rated semi-dependent or dependent in behavior pattern and orientation: ❑ *YES*; **PLUS**
Rated semi-dependent in joint motion or semi-dependent in medication administration: ❑ *YES.*

NF CATEGORY 2:

Rated dependent in 5 to 7 ADLs: ❑ *YES;* **PLUS**
Rated dependent in mobility: ❑ *YES.*

NF CATEGORY 3:

Rated semi-dependent in 2-7 ADLS: ❑ *YES:* **PLUS**
Rated dependent in behavior and orientation: ❑ *YES.*

Indicate whether the individual has medical nursing needs. This means: 1) the individual's medical condition requires observation and assessment to assure evaluation of needs due to an inability for self-observation or evaluation; OR 2) the individual has complex medical conditions that may be unstable or have the potential for instability; OR 3) the individual requires at least one ongoing medical or nursing service.

To meet NF Criteria, the individual must meet at least one of the three categories (meaning he or she meets **all** elements within the category) AND the individual must have medical nursing needs.

Services:

- Dietary Services
- Medically Necessary Supplies
- Nursing Services
- Physical/Occupational/Speech Therapy
- Prescription Drugs
- Recreational Therapy
- Social Services

Screening Process: For public pay participants, the Preadmission Screening (PAS) Team must assess the participant using the Virginia UAI prior to provision of services.

Forms:

- Completed Virginia UAI (all 12 pages)
- Completed DMAS-96 form
- Completed DMAS-95 MI/MR Level 1 form
- Completed DMAS-95 MI/MR Level 2 form (if applicable)
- Copy of DMAS-97 form

SPECIALIZED CARE

If a participant requires nursing facility care and has specialized service needs, it may be appropriate to refer to a specialized care provider. Specialized services are available for children, such as for ventilator care, intravenous medication or nutrition, certain complex medical care, and comprehensive rehabilitation therapy. For adults, the program is limited to ventilator care and complex tracheostomy care.

In order to receive these services, a participant must meet basic nursing facility level of care and have completed a preadmission screening which authorizes nursing facility placement.

VIII. COMMUNITY-BASED SERVICES

Community-based services should be considered when an individual meets NF criteria and is at risk of NF placement (as defined below) without waiver services. Waiver services are offered to such an individual as an alternative to avoid NF admission. "Imminent risk of nursing facility placement" is defined as being when the individual needs to enter a NF within one month if he or she does not receive waiver services.

ALZHEIMER'S ASSISTED LIVING WAIVER

Services:

- Assistance with activities of daily living;
- Medication administration by registered or licensed professionals;
- Licensed Health Care Professional services for assessments, evaluations, and Coordination of Services; and
- Therapeutic, social, and recreational programming that provides daily activities for participants with dementia.

Criteria:

- Be an Auxiliary Grant (AG) recipient; AND
- Have a diagnosis of Alzheimer's Disease or a related dementia and no diagnosis of serious mental illness or mental retardation; AND
- Reside in an approved ALF that is licensed by VDSS as a "safe and secure" environment; AND
- Meet nursing facility level of care.

Screening Process: For public pay participants, the PAS Team must assess the adult participant, using the UAI, prior to provision of services. Alternative institutional placement is a nursing facility. The participant or his or her family must locate a qualified facility and confirm admission. The ALF will notify DMAS of admission.

Forms:

- Completed UAI (all 12 pages)
- Completed DMAS-96 form

Points to Consider:

Does the individual have a diagnosis of Alzheimer's disease or a related dementia?
Does the individual meet NF criteria?
Is the individual receiving an Auxiliary Grant (AG)?
If yes to all of these questions, then authorization to the Alzheimer's Assisted Living Waiver may be appropriate.

DAY SUPPORT WAIVER

The Day Support Waiver is administered by the DMHMRSAS Office of ID/MR in collaboration with DMAS.

Eligibility: Persons on the ID/MR waiver Urgent or Non-Urgent Waiting Lists are eligible if they have a MR diagnosis. Participants are selected according to the date when services were first necessary, regardless of urgency. A participant can remain on the waiting list for the ID/MR Waiver while being served by the Day Support Waiver, and transfer to the ID/MR Waiver once a slot becomes available.

Services:

- Day support;
- Prevocational services;

Screening Process: Contact the local community services board (CSB) or behavioral health authority (BHA) to request a screening using the "Level of Functioning" survey. The local PAS Team does NOT assess participants for the DS Waiver.

ELDERLY OR DISABLED WITH CONSUMER DIRECTION (EDCD) WAIVER

Eligibility: This waiver serves the elderly and persons of all ages with disabilities. The participant may receive this service through a service provider or through consumer direction in which he or she directs his or her own care, or a parent, spouse, adult child or other responsible adult can direct care on behalf of the participant. A participant can remain on the waiting list for another waiver while being served by the EDCD Waiver if he or she meets criteria for both waivers and transfers to the preferred waiver once a slot becomes available.

Services:

- Adult Day Health Care.
- Assistive Technology (NEW)
- Environmental Modifications (NEW)
- Medication Monitoring – Installation and Monthly.
- Personal Care – Agency and Consumer-Directed.
- Personal Emergency Response System (PERS) – Installation and may or may not include monthly monitoring. This is not a stand alone service and must be authorized in addition to one of the other services available in this waiver.
- Respite Care – Agency and Consumer-Directed.
- Transition Coordination (NEW)
- Transitional Services (NEW)

Criteria: A participant must meet NF eligibility criteria, including both medical needs and functional capacity needs (assistance with ADLs) and must be at imminent risk of NF placement.

Screening Process: For public pay participants, the local PAS Team must assess the participant prior to provision of services.

Forms Required:

- Completed Virginia UAI (all 12 pages)
- Completed DMAS-96 form
- Completed DMAS-97 form
- Completed DMAS-95 Level I MI/MR form
- Completed DMAS-101B form (if applicable)
- Completed DMAS-95 Addendum for CDPAS (if applicable)

Points to Consider:

Is the individual elderly or have a disability without conditions cited in the MR Waiver, HIV/AIDS Waiver, or Tech Waiver?
Is the individual interested in adult day health care?
If yes to either of these questions, then authorization to the EDCD Waiver may be appropriate.

HIV/AIDS WAIVER

Services:

- Assistive Technology (NEW)
- Case management
- Environmental Modifications (NEW)
- Nutritional Supplements
- Personal Emergency Response System (PERS)
- Personal Care – Agency Directed and Consumer Directed
- Private Duty Nursing – RN and LPN
- Respite Care – Agency-Directed or Consumer-Directed
- Transitional Services (NEW)

Criteria:

- Diagnosis of HIV/AIDS or ARC (AIDS-related condition); AND
- Documentation that participant is experiencing medical and functional symptoms associated with HIV/AIDS or ARC which would require NF or hospital care; AND
- The participant meets NF criteria.

Screening Process: For public pay participants, the PAS Team must assess the participant prior to provision of services.

Forms:

- Completed UAI (all 12 pages)
- Completed DMAS-96 form
- Completed DMAS-113 A and DMAS-113B forms
- Completed DMAS-97 form

Points to Consider:

Has the individual been diagnosed with symptomatic HIV or AIDS and is experiencing debilitating medical and functional symptoms?
Has the individual been diagnosed with symptomatic HIV or AIDS and has skilled needs that require home health or skilled nursing?
If yes to either of these questions, then authorization to the HIV/AIDS Waiver may be appropriate.

INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SERVICES (IFDDS) WAIVER

Eligibility: The IFDDS Waiver provides services to participants 6 years of age and older who have a diagnosis of a DD and do not have a diagnosis of MR. Participants also must require the level of care provided in an intermediate-care facility for persons with ID/MR or other related conditions (ICF/MR). Children who do not have a diagnosis of ID/MR, and have received services through the ID/MR Waiver, become ineligible for the ID/MR Waiver when they reach the age of 6. At that time, they can be screened for eligibility for the IFDDS Waiver; if found eligible, they may receive an IFDDS waiver slot subject to CMS approval.

Services:

- Adult Companion Services – Agency Directed
- Assistive Technology
- Crisis Stabilization
- Crisis Supervision
- Day Support - High Intensity and Regular
- Environmental Modifications
- Family/Caregiver Training
- In-home Residential Support (not group homes)
- Personal Care – Agency Directed and Consumer Directed
- Personal Emergency Response System (PERS)
- Prevocational Training
- Respite Care – Agency Directed and Consumer Directed
- Skilled Nursing RN
- Support Coordination (Case Management)
- Supported Employment – Enclave and Individual
- Therapeutic Consultation
- Transitional Services (NEW)

Criteria:

- Must be 6 years of age and over and meet the related conditions requirements of 42 CFR § 435.1009, including autism; AND
- Not have a diagnosis of ID/MR as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD); AND
- Meet the level of care for admission to an ICF/MR; AND
- Meet at least two level-of-functioning indicators.

Screening Process:

- The Virginia Department of Health Child Development Clinics will screen participants with the Level of Functioning (LOF) Survey which is the assessment instrument used to determine eligibility for an ICF/MR. Download a copy of the "Request for Screening" form (available at www.dmas.virginia.gov/content/ltc-dd_wvr_request_for_services.htm -- click on link at top of page). Complete the form and fax or mail it to the Child Development Center in your locality (see same Webpage). The psychological assessment is a requirement of the screening determination.

Forms:

- Medicaid-Funded Long-Term Care Authorization (DMAS-96)
- Documentation of Individual Choice between Institutional Care and Home- and Community-based Services (DMAS- 459)
- Provider consent form
- IFDDS Medicaid Waiver Level of Functioning Survey Summary Sheet (DMAS-458)

Points to Consider:

Has the individual been diagnosed with a developmental disability (other than MR)?
Is the individual 6 years of age or older and meet the "related conditions" requirements of 42 CFR 435.1009, including autism?
If yes to either of these questions, then authorization to the IFDDS Waiver may be appropriate.

COMMUNITY-BASED SERVICES: IFDDS WAIVER / ID/MR WAIVER

INTELLECTUAL DISABILITY/MENTAL RETARDATION (MR) WAIVER

Eligibility: A participant must be age 6 or older and have a diagnosis of MR OR be under age 6 and at developmental risk. The person must be eligible for placement in an intermediate-care facility for persons with ID/MR or other related conditions (ICF/MR). Community services boards (CSBs) are given a number of slots to manage and cannot exceed their slot allocation. This waiver is "needs-based," meaning those who meet urgent criteria are served first. Children on the ID/MR Waiver who do not have a diagnosis MR should be screened at age 6 and may transfer to the IFDDS Waiver if eligible and subject to CMS approval.

Services:

- Adult Companion Care – Agency-Directed and Consumer-Directed
- Assistive Technology Day Support
- Congregate Residential
- Crisis Stabilization
- Crisis Supervision
- Day Support – Regular and High Intensity
- Environmental Modifications
- Family/Caregiver Training
- In-Home Residential
- Medication Monitoring – Installation and Monthly
- Personal Emergency Response System (PERS) – Monitoring and LPN and RN
- Personal Care – Agency-Directed and Consumer-Directed
- Prevocational Services – regular and high intensity
- Residential Support
- Respite Care – Agency-Directed and Consumer-Directed (72 hours max/year)
- Skilled Nursing RN and LPN
- Supported Employment – Enclave and Individual
- Therapeutic Consultation
- Transitional Services (NEW)

Criteria:

- Must meet criteria for ICF/MR; AND
- Must have MR or related condition OR under age 6 at developmental risk who requires a level of care in an ICF/MR. At age 6, the child must have MR; AND
- Must meet at least two level-of-functioning indicators.

Screening Process: Participants with MR must be screened by the local CSB or behavioral health authority (BHA) to request a screening using the "Level of Functioning"(LOF) survey.

Forms:

- Level of Functioning Form
- Agency Consent
- Choice of Services Forms
- Documentation of Individual Choice between Institutional Care and Home- and Community-based Services

Waiting List: There are 3 types of lists for the MR Waiver. MR Waiver slots are given first to participants who meet the criteria for the Urgent Waiting List.

- Urgent Waiting List – needing waiver services immediately
- Non-urgent Waiting List – needing waiver services within 30 days
- Planning List – will need waiver services at some point in the future

Points to Consider:

Has the individual been diagnosed with MR or a related condition?
Does the individual require specialized training to enhance skills, supported employment, therapeutic consultation, assistive technology, day support, residential support, personal care, private duty nursing, crisis stabilization, or environmental modifications to provide optimal level of care?
If yes to either of the questions, then authorization to the MR Waiver may be appropriate.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Services:

- Adult Day Care
- Home Health Care
- Hospital Patient Care
- Meals
- Nursing Facility Care
- Nutritional Counseling
- Outpatient Medical Services
- Personal Care
- Prescribed Medications
- Primary/Specialty Care
- Private Duty Nursing
- Respite Care
- Social Services
- Transportation
- All Other Medicare and Medicaid Services

Criteria:

- Be 55 years of age or older; AND
- Reside in a PACE provider's service area; AND
- Be determined eligible for NF care; AND
- Be screened and assessed by the PACE team; AND
- Have a safe service plan; AND
- Agree to the terms and conditions of participation; AND
- Have an income equal to or less than 300% of the current Social Security Income.

Screening Process: For public pay participants, the PAS Team must assess the participant prior to provision of services. Participants transitioning from the EDCD or HIV/AIDS Waivers or from a NF and who previously had a preadmission screening completed authorizing this level of service may move to the PACE program without any additional screenings being completed.

Forms Required to Begin Services:

- Enrollment Assessment Instrument (DMAS-99P)
- Virginia UAI
- Service Plan

Points to Consider:

Does the individual reside in a PACE service area?
Is the individual interested in obtaining all-inclusive services through one-stop care at an adult day health care center?
Does the individual agree to the terms and conditions of participation, including receiving services from a PACE physician?
If yes to any of these questions, then authorization to PACE may be appropriate.

TECHNOLOGY ASSISTED WAIVER

Eligibility: Children and adults must require substantial and ongoing skilled nursing care. Children under the age of 21 are eligible if they are dependent on technology to substitute for a vital body function and have exhausted available third-party insurance benefits for private-duty nursing. The participant must have a primary back up person to assume care when the skilled nurse is not available. Tech Waiver services may be limited or denied for participants who can receive services through a third-party payment source.

Services:

- Assistive Technology
- Environmental Modifications
- Personal Emergency Response System (PERS) (NEW)
- Personal Care – Agency Directed (participants must be 21 years of age or older)
- Private Duty Nursing (PDN) – RN and LPN
- Skilled PDN
- Respite Care (Agency-directed)
- Transitional Services (NEW)

Criteria:

- Doctor must certify need for care; AND
- Need substantial and ongoing skilled nursing care; AND
- Care must be cost-effective; AND
- Have a trained, primary caregiver who provides at least 8 hours of care for each 24-hour day.
- **Younger than 21**: Dependent at least part of the day on a mechanical ventilator OR dependent on technology such as a tracheostomy, prolonged I.V. nutritional supplements, drugs, or peritoneal dialysis; OR daily dependence on other device-based respiratory or nutritional support, including tracheostomy care, oxygen support, or tube feeding.
- **21 and older**: Requires ongoing and substantial nursing care and is: dependent on mechanical ventilator OR requires complex tracheostomy services.

Screening Process:

- The Tech Waiver referral, regardless of a participants' age, originates from a hospital, nursing facility, or the community.
- Technology Assisted Waiver must have a Virginia UAI completed by the local PAS Team in the community or by a nursing facility or hospital discharge planner. If appropriate, these participants must also be referred for a Level II screening for conditions of mental health and/or MR. The UAI assessment is completed by a medical professional (a RN and/or Social Worker and a physician).
- The complete screening packet is sent to the DMAS Health Care Coordinator (HCC) for final eligibility determination and enrollment authorization for private duty nursing.
- DMAS makes the final determination for waiver enrollment.

Forms:

- **Under 21:** Virginia UAI, DMAS 96, DMAS 97, Technology Waiver Pediatric Referral form.
- **Over 21:** Virginia UAI, DMAS 96, DMAS 97, Technology Waiver Adult Referral form.

Money Follows the Person (MFP)

Money Follows the Person (MFP) is a demonstration project that allows qualified individuals of all ages and all disabilities the option for community living.

Eligibility:

The participant must:

- Be a resident of Virginia;
- Reside in a nursing facility, intermediate care facility for persons with intellectual disabilities/mental retardation, or long-stay hospitals for **six consecutive months**; and
- Be eligible for enrollment in a LTC Medicaid Waiver; and
- Be eligible for Medicaid for at least one month at the time of transition.

Services:

- **Transition Coordination** – DMAS-enrolled provider responsible for supporting the participant and family/caregiver, as appropriate, with the activities associated with transitioning from an institution to the community. This service is only available in the EDCD Waiver.

To qualify for these services, a participant must demonstrate a need for transition coordination. Transition coordination services must be prior authorized by DMAS or its designated agent.

- **Transition Services** – a one-time, life-time $5,000 benefit pre-authorized by DMAS (or its' agent) to assist in procuring essential goods and services to permit transition to a community setting. This benefit must be expended within nine months from the date of authorization. Examples of allowable costs include, and are not limited to, security deposits, essential household furnishings, and set-up fees or deposits for utility or services access. Excluded are monthly rent, mortgage expenses, or food; regular utility charges; household items intended for purely diversional/recreational purposes; and/or items that are covered under other waiver services.

Services added to Waivers:

- EDCD – Environmental Modifications, Assistive Technology, PERS, Transition Coordination, Transition Services
- Tech – PERS, Transition Services
- HIV/AIDS – Environmental Modifications, Assistive Technology, Transition Services
- IFDDS – Transition Services
- ID/MR – Transition Services

*All services added to the waivers are permanent additions to the specific waiver program.

Enrollment Process:

- Facility discharge staff should assist the participant in obtaining necessary information to make an informed choice regarding the MFP program.
- A case manager, transition coordinator, or other appropriate provider will gather:
  - Assessment Instrument(s);
  - Service Plan;
  - Risk Assessment; and
  - MFP Enrollment Forms: DMAS-222 MFP Enrollment, DMAS-221 MFP Informed Consent, and DMAS-416 MFP Quality of Life Survey.
- The case manager, transition coordinator, or other appropriate provider will then submit (1) the Waiver Enrollment to the appropriate entity for processing and (2) Prior Authorization requests to the appropriate entity for processing.
- If a participant is using the ID/MR Waiver, his/her Community Services Board will designate a case manager.
- Waiver enrollment process will be based on the procedures used by the waiver in which a person enrolls.

For more information about MFP, please visit http://www.olmsteadva.com/mfp or e-mail MFP@dmas.virginia.gov or call the Division of Long-Term Care (804) 225-4222.